

MDR Tracking Number: M5-04-2935-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 05-07-04. Dates of service 04-24-03 through 05-01-03 per Rule 133.308(e)(1) were not timely filed and will not be reviewed by the Medical Review Division.

The IRO reviewed office visits with manipulation, joint mobilization, myofascial release, electrical stimulation unattended, hot/cold pack therapy, therapeutic exercises, manual therapy technique, chiropractic manipulative treatment and ultrasound therapy rendered from 05-08-03 through 09-02-03 that were denied based upon "V".

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the **majority** of issues of medical necessity. Consequently, the requestor is not owed a refund of the paid IRO fee.

The IRO determined that the services rendered through date of service 07-14-03 **were not** medically necessary. The IRO determined that services rendered on 08-13-03, 08-15-03 and 09-02-03 **were** medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 05-07-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

CPT code 99080-73 date of service 07-14-03 denied with a "U" denial code. The TWCC-73 is a required report and is not subject to an IRO review. The Medical Review Division has jurisdiction in this matter. Reimbursement in the amount of \$15.00 is recommended.

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this order. This Decision is applicable for dates of service 07-14-03 through 09-02-03 in this dispute.

This Findings and Decision and Order are hereby issued this 7th day of October 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh

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NOTICE OF INDEPENDENT REVIEW DECISION

July 21, 2004

Re: IRO Case # M5-04-2935

Texas Worker's Compensation Commission:

Envoy Medical Systems, LP (Envoy) has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule 133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to Envoy for an independent review. Envoy has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, Envoy received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a physician who is Board Certified in Orthopedic Surgery, and who has met the requirements for TWCC Approved Doctor List or has been approved as an exception to the Approved Doctor List. He or she has signed a certification statement attesting that no known conflicts of interest exist between him or her and any of the treating physicians or providers, or any of the physicians or providers who reviewed the case for a determination prior to referral to Envoy for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the Envoy reviewer who reviewed this case, based on the medical records provided, is as follows:

Medical Information Reviewed

1. Table of disputed service 12/30/02 – 10/13/03
2. Explanation of benefits
3. Peer reviews 5/7/03, 10/31/03, reconsideration 6/11/03,
4. Medical records from treatment provider
5. Orthopedic notes and reports
6. Physical medicine rehabilitation evaluation 9/5/02
7. NCS report 9/13/02
8. Repeat NCS report
9. X-ray reports cervical spine, wrist, bilateral elbows
10. MRI report left elbow
11. MRI report left shoulder

History

The patient is a 27-year-old female who reported injury due to repetitive activities in _____. The patient had symptoms of numbness in both hands (greater on the left than on the right), bilateral elbow pain, posterior left elbow pain and left shoulder pain. She was diagnosed with left rotator cuff syndrome, lateral epicondylitis, left triceps tendon tendonitis, and carpal tunnel syndrome. The patient received extensive conservative treatment, including physical therapy and multiple steroid injections into the shoulder and elbow. An MRI of the wrist was negative. An MRI of the shoulder revealed a partial thickness supraspinatus tear and impingement from the AC joint. On 7/18/03 the patient underwent left shoulder arthroscopy with debridement of the partial rotator cuff tear, subacromial decompression, and distal clavectomy, as well as a left elbow steroid injection.

Requested Service(s)

MP –OV, joint mobilization, myofascial release, elec stim unattended, hot cold pack, therapeutic exercises, manual therapy technique, chiropractic man treatment, ultrasound 5/8/03 –9/2/03

Decision

I agree with the carrier's decision to deny the requested service through 7/14/03.

I disagree with the decision to deny the requested services on 8/13/03, 8/15/03 and 9/2/03

Rationale

Based on the documentation provided, the patient had not responded well to extensive non-operative management. There was a lack of progression in treatment, and the records do not adequately support or justify the ongoing physical treatment and/or modalities.

Services on the dates through 7/14/03 represent pre-operative therapy for a patient who is already a surgical candidate and has demonstrated a poor response to previous physical therapy. Therefore, the services through 7/14/03 were not reasonable or necessary.

The visits and services on 8/13/03, 8/15/03 and 9/2/03 represent post-surgical physical therapy and they appear from the records to be medically necessary and reasonable.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.
